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Biological & Medical Serials

THE

Maritime Medical News

A MONTHLY JOURNAL OF

MEDICINE AND SURGERY.

Vol. XVI. HALIFAX, NOVA SCOTIA, MAY, 1904. No. 5

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(Pass Primary M. D., C. M. examination).

3RD YEAR.—Surgery, Medicine, Obstetrics, Medical Jurisprudence, Clinical Surgery, Clinical Medicine, Pathology, Bacteriology, Hospital, Practical Obstetrics, Therapeutics.
(Pass in Medical Jurisprudence, Pathology, Therapetics.)

4TH YEAR.—Surgery, Medicine, Gynæcology and Diseases of Children, Ophthalmology, Cli nical M ed cine, Clinical Surgery, Practical Obstetrics, Hospital, Vaccination, Applied Aanatomy.
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Extract from Constitution:

"All registered practitioners in the Maritime Provinces are eligible for membership in this Association."

All who intend to read papers at this meeting will kindly notify the Secretary as early as possible.

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A MONTHLY JOURNAL OF MEDICINE AND SURGERY

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CONTENTS FOR MAY, 1904.

ORIGINAL COMMUNICATIONS.

Vomiting of Pregnancy in a Primipara with a Double Uterus (Uterus Septus)—E. B. Roach 159

The White Blood Cells in the Diagnosis of Disease—L. M. Murray 165

The Smallpox Epidemic—Persistence of the Contagium of Smallpox—A. P. Reid 171

Climacteric Insanity—G. A. B. Addy 176

Remarks on Ocular Paralysis, with Case Report.—G. R. J. Crawford .. 179

SELECTED ARTICLE.

Don'ts in Modern Gynecology—Lucien Lofton 181

EDITORIAL.

The Provincial Sanitarium 184

Canadian Medical Association 186

SOCIETY MEETINGS.

N. S. Branch British Medical Association 188

Personals 191

OBITUARY.

Dr. W. W. Wickham 192

Matters Medical 193

Therapeutic Notes 193

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Original Communications.

VOMITING OF PREGNANCY IN A PRIMIPARA WITH A DOUBLE UTERUS (UTERUS SEPTUS).

By E. B. ROACH, M. D., Tatamagouche, N. S.

Mrs. C., aged 25 years, primipara.

Previous history: From childhood patient had always been delicate. She was of a nervous temperament, and as a student worked hard to get her education. For some years previous to marriage she was subject to spells of loss of consciousness, brought on chiefly by freight. These were called fainting turns by some, while others thought they were the result of an injury to her head in a railway accident. Having seen her at one of these times, my personal opinion was that they were minor seizures of hysteria. For some years before marriage she was anæmic, constipated and generally depressed in vitality. Menstruation had always been irregular, scanty and accompanied by a good deal of pain. She was married on August 19th, 1903, and was scarcely able to stand during the ceremony. The first menstrual period, after marriage, was from September 15th to 19th, the second one on October 24th, which lasted a few hours only and reappeared for a short time on October 25th.

Her illness dates from this time, when vomiting began. At first it was not bad, and she was made to stay in bed the first part of the day, but, being determined to get up, was allowed to do so and endeavour to work. Her appetite, which had been poor, gradually got

* Read before the Colchester Medical Society. January, 1904.

worse until she could not take any food without almost immediately vomiting it up. This condition was daily going from bad to worse; still she was allowed to get up and be carried down stairs, where she would lie on a sofa and try to do some light work, such as sewing and knitting.

For about two weeks this went on, and she absolutely refused to see a doctor. I was consulted at my office about her on Nov. 7th, and prescribed absolute rest in bed, rectal alimentation and bromides. On Monday, November 9th, she consented to have me see her, and I was surprised to find her physical condition so good. There was not any noticeable loss of flesh and the pulse and temperature were normal. The vomiting this day was not severe, but, on questioning, I found that on the Friday previous she had vomited about every ten minutes, being somewhat better on Saturday. Rectal alimentation had been started just twenty-four hours before I saw her. Her condition was good, and with absolute rest and the treatment prescribed I thought she would, in a short time, be much better.

The treatment given from the first day I saw her was as follows:

(1.) Absolute rest in bed with room darkened.

(2.) Rectal alimentation every four hours, consisting of peptonized milk with the white of two eggs, sometimes the whole egg, giving about four or five ounces at each feeding.

(3.) Potass. bromide, grs. xxx, three times a day in food or starch water. After a few days this was changed to potass. bromide and chloral hydrate morning and night.

(4.) Absolute rest for the stomach, except cold water, which she always retained.

(5.) Lower bowels to be washed out with warm water as a cleansing enema morning and night.

(6.) As much quiet in the house as possible.

I asked for a vaginal examination, but patient was so much opposed to it, that I decided not to insist upon it the first day. At this time she had considerable pain in her stomach and intestines after the rectal injection. The warm water injection gave her the most pain, so much so, that almost from the first, it caused peculiar turns of loss of consciousness, lasting from twenty to forty-five minutes. Headache soon became very severe, and lasted throughout her entire illness. The vomiting, the first few days, did not occur very often, but the nausea was intense.

On the evening of my second day's attendance I had a consultation with Dr. McLeod, of Wallace, chiefly to satisfy myself as to pregnancy. On examination we were both agreed she was pregnant, and that pregnancy was the cause of the vomiting. My consultant did not think the case a serious one, and quite concurred in the line of treatment I had adopted. On the third day the services of a professional nurse were obtained, and the effect upon the patient was quite noticeable, as there was a decided improvement in the vomiting, which was absent for thirty-six hours at one time. This looked quite encouraging, still there were present distressing symptoms, such as almost constant nausea, violent headache, pain in the stomach, abdomen, and rectum after food, and spells of loss of consciousness after the cleansing enemata. Thirst became a prominent symptom toward the end of the week, with parched lips and dry tongue, so she was given high enemata of warm saline, also water in small quantities by the mouth.

After having given the stomach a complete rest for some days she was given teaspoonful doses of milk and lime water, barley water, beef juice and albumen water, for all of which she had an absolute disgust. There was so much general pain that I stopped the chloral and used tincture of opium combined with the bromide, but with no apparent benefit. I then tried morphine hypodermically in one-eighth and one-fourth grain doses, but, every time it was used, a rigor of all of the voluntary muscles of the body followed with unconsciousness. This taking place after each one of the three injections, I did not feel justified in continuing it. The vomiting had been very erratic, not frequent, as the patient tried her utmost to restrain it. Specks of blood were seen a number of times and a good deal of bile. The temperature kept normal, pulse 70 to 75 when quiet, but, after vomiting, would run up to 90 and 95.

Finding that the nerve sedatives did not have much effect in stopping the vomiting, I used all of the remedies recommended, such as bismuth, cocaine, cerium oxalate, tincture of iodine, carbolic acid, and heroin in place of opium by the rectum. The bromide and chloral caused so much pain, when given with the nutritive enemata, that they were given in starch water, but although there was less pain, the extra number of manipulations necessary about conterbalanced the lessened amount of pain. Another symptom not mentioned, and one which showed her marked neurotic condition, was that she had hallucina-

tions, imagining she saw beasts and snakes on the wall. She also talked a great deal about a railway accident and being buried at sea. When any one came into the room, she beeame greatly alarmed, would jump to the other side of the bed, not seeming to know who stood before her.

After a week of such attendance I realized that I had to deal with a very difficult case, and more than once the question "should the uterus be emptied" presented itself to me. Considering that as yet there was no emaciation, a normal temperature, pulse 75 of average tension, and the vomiting erratic, I feel you will agree with me in saying that I was justified in temporizing. Hirst, a leading American author on obstetrics, says that the induction of abortion is imperative if the vomiting is incessant and the pulse up to 120.

The condition of the patient continued about the same, with treatment varied as I thought the indications required, up to November 21st, the twelfth day I had been in attendance, when I had Dr. McIntosh, of Pugwash, in consultation, with the intention of inducing abortion if he advised it. He thought there was no use in temporizing further, so we proceeded as follows:

Patient was placed on a table in the lithotomy position and anæsthetized with chloroform. A vaginal douche of bichloride of mercury 1 to 2000 was given, and a Grave's bivalve speculum inserted. At this time it was noticed that the cervix projected into the vagina in an abnormal position, being almost to the extreme left, instead of the centre as normally. A uterine sound was inserted and passed for $3\frac{1}{2}$ or 4 inches. Seizing the anterior lip of the cervix with a vulsellum forceps, a small dilator was inserted without difficulty, but on attempting to dilate, the tissues of the cervix seemed very resistant. A large parallel dilator was then used, but at first it seemed impossible to get it to pass more than half of the proper distance. Not understanding why there should be such resistance, I inserted my index finger, which passed the cervical canal with difficulty. On pushing it still further it entered a small cavity about an inch or more in length, and barely large enough for point of my finger to be inserted with great pressure. I said to my consultant that it was not a pregnant uterus into which my finger had passed, and he replied that possibly I had not gone beyond the internal os. Dr. McIntosh then examined her and on using the large dilator it passed into the larger or true uterine cavity, whereas with me it had passed to the right of the septum into the

smaller or accessory cavity. While my consultant was dilating a bilateral tear of the cervix occurred, and the tissues were so rigid that their giving away produced a sound quite audible across the room. He thought he had ruptured the uterus, but on resuming the work I could easily see the tear from which there was a little hemorrhage. On again using my finger it passed quite easily into the larger cavity and I could feel the fœtal appendages. There was some hemorrhage, and, in the face of a possible rupture, which we still thought improbable, we decided not to curette but to tampon, considering that the previous manipulations would without delay cause the expulsion of the fœtus. The uterus was then lightly packed with iodoform gauze and the vagina tamponed tightly. Patient came out of the chloroform nicely, not much depressed, but with severe pain. Not even at this time did we know we were dealing with a double uterus, as I attributed the difficulty I had with my finger and the dilator as due to not having passed the internal os. In three hours the packing was removed, a douche given, and as there was no sign of an ovum the vagina was tightly tamponed. The vomiting still occurred at irregular intervals. On the following day the temperature was 100, and the pulse had run up to 115 and was weaker. She was placed across the bed, the gauze removed with great pain, and an intrauterine douche of creolin 3 per cent given. Still the uterus showed no sign of expelling its contents, and the vagina was again tamponed. The possibility of a double uterus occurred to me that evening and I told my consultant so in letting him know by telephone our patient's condition. Next morning we again met and decided to curette, or, if possible, remove fœtus *en masse* with placental forceps. That morning the temperature was 101, and the pulse had become very rapid, being 150 just before putting her on the table. The cervix was again greatly dilated, and on passing my index finger I could at will put it into either one of the two cavities. It was not until now that the true condition was known to us. The cavity on the right was very small, and there was a distinct circular or oval opening from it leading into the cervical canal at about the level of the internal os. The large cavity, which contained the fœtus, was to the left and seemed enlarged to that side with a convex surface much like the lower border of the stomach. The fœtus could easily be felt and was attached just above the internal os to the left, in the position of what would have been a lateral placenta prævia had she lived and gone to term. Its connection with the

uterine wall was so firm that I could not make any impression on it with my finger, so passed in placental forceps and brought it away entire. There was no hemorrhage, so a douche was given and a light tampon inserted. Patient had only taken about a drachm of chloroform, and when placed in bed was very weak. The foot of the bed was at once elevated. Strychnia and digitalin were given hypodermically and a high injection of hot saline. The pulse gradually grew weaker, and I resorted to all possible means of stimulation, using strychnia and digitalin hypodermically in larger doses, hot coffee and brandy, hypodermoclysis, putting a pint and a half under each breast, and amyl nitrite by inhalation. In spite of all this she passed away about nine hours after the operation without regaining consciousness.

In conclusion, I would like to emphasize some of the severe aspects of this case, and ask for information.

Why was there such severe and constant headache, which would not yield even to opium?

Why was there such excruciating pain in the stomach, intestines and the rectum, after the injections of warm water?

Why did the hypodermic injections of morphine in one-eighth and one-fourth grain doses cause rigor of all the voluntary muscles of the body?

What was the cause of the loss of consciousness every time a cleansing enema was given?

What was the cause of the hallucinations?

Finally, I would like to emphasize how we should always be on the watch for abnormalities. This case points out that menstruation is not always a symptom of the non-pregnant state, for while she was menstruating from one cavity of the uterus she was pregnant in the other.

THE WHITE BLOOD CELLS IN THE DIAGNOSIS OF DISEASE.*

By L. M. Murray, M. D., Halifax, Pathologist to the Province of Nova Scotia.

As I have known for some time that the pathological meeting of this society was to be held in this laboratory, it has worried me not a little to know how I could interest you for a short time; and it is only recently, after having been connected with several cases presenting interesting blood pictures, that it occurred to me that you might be interested in examining some of these blood slides and at the same time review some portion of the work of blood examination.

While admitting an error in taking a superficial view of any portion of a medical examination, I thought that if we could go over, even rapidly, the changes which occur in the white blood corpuscles in diseased conditions it might be more interesting to you than confining ourselves to but one portion of the subject.

The red blood cells observed in the earlier embryonic existence of man and other mammals resembles those which persist throughout the life of the lower vertebrates in being nucleated cells, and in some of the blood slides under the microscope you will see some of these nucleated cells, showing no doubt a reversion to an earlier type in diseased conditions of the blood-forming organs. In the human embryo at the end of the fourth week all of the red blood cells are nucleated; at the third month nucleated cells form one-sixth to one-eighth of the red blood corpuscles, while at birth nucleated red cells are entirely absent, having been completely replaced in the circulating blood by the biconcave discs which characterize the blood in the mammalian adult. The blood platelets and leucocytes appear in the blood at a later period than the red blood cells; however, they are to be seen about the fifth month of uterine life.

In extra-uterine life it is generally believed that, except under very abnormal conditions, no red blood cells are formed except in the red marrow of bones. At first these cells are nucleated, but, as you know, as they are circulating in the blood they have lost their

*Read before N. S. Branch British Medical Association, March 2nd, 1904.

nucleus. It is possible also, under certain conditions, as following a severe hemorrhage, that the red blood cells may also be formed in the spleen and lymphatic glands.

In regard to the white blood cells—the different varities of which I have pictured on the board-- it is agreed that the lymphocyte is the youngest form of leucocyte found in the blood, and that it is probably formed in the lymphatic tissues of the body, and possibly also in the splenic pulp and in the red marrow of bones. It first arrives in the blood as a small cell with a prominent nucleus, surrounded by only a trace of protoplasm, and is known as a lymphocyte. It is then incapable of amœboid movement, but in the process of growth it gives rise to a larger cell having amœboid movement and possessing a large envelope of finely granular protoplasm around its nucleus. In some varieties of this stage the granules in the cell protoplasm are more conspicuous than in others.

The next development takes place by an alteration in the nucleus, which is no longer spherical or oval but becomes drawn into a horse-shoe shape or folded over on itself so as to resemble a multiple nucleus. This gives rise to the polymorphonuclear cell, which is still capable of amœboid movement, and may, by fragmentation of the complex nucleus, give rise to the multinuclear leucocyte.

Other and different classifications of the normal leucocyte, which you may see mentioned, are based upon a reaction of the protoplasmic granules toward the different stains. Ehrlich, for instance, divides the leucocytes into three groups, according to the size and staining of the granules found in the protoplasm. The oxyphiles or eosinophiles or acidophiles are those whose granules stain only with the acid aniline dyes like eosin. The basophiles are those whose granules stain only with the basic dyes, and the neutrophiles whose granules stain only with neutral dyes.

In normal blood the leucocytes number from 6000 to 9000 per c. m.; but, as the number varies a good deal in different individuals, the normal leucocyte count for any one individual can only be determined after the blood has been examined several times. A differential leucocyte count of normal blood will show the lymphocytes as 20 to 30 per cent. of the white cells. The large mononuclear cells as from 2 to 3 per cent.; the polymorphonuclear from 60 to 70 per cent; the eosinophiles from 2 to 3 per cent; and the mast-cells (cells having large basophilic granules) about $\frac{1}{4}$ to 1 per cent.

Myelocytes, which are large cells having neutrophilic granules, are to be found in the bone marrow, and only occur in the blood in pathological conditions.

While a leucocyte count and the examination of the white blood cells in any given case are in themselves useless, I hope to show you that when considered with other data they become of great diagnostic and prognostic value.

Passing from normal blood we will first consider the condition known as leucocytosis, in which we get an increase of the number of leucocytes in the circulating blood above that which is normal for the individual. But in considering leucocytosis it is well to keep in mind the fact that an increase in the number of the leucocytes may be quite physiological, as in the new born child they number about 17,000 per c. m. During digestion they number about 12,000 per c. m. In the later months of pregnancy they average 13,000 per c. m. Post partum they number between 10,000 and 13,000 per c.m. This increase must be remembered particularly if the blood is being examined at this period for the possibility of sepsis. The leucocytes are also increased above the ordinary count after violent exercise, and also just before death. Of the leucocytosis found as a symptom of a pathological condition, Cabot has the following classification:

1. Post hæmorrhagic.
2. Inflammatory.
3. Toxic.
4. In malignant disease.
5. Therapeutic and experimental.

In these conditions the increase in the number of the leucocytes is as a consequence of a pathological condition—for we cannot speak of the leucocytosis in itself as being pathological—and is due to the influence of chemiotaxis.

The chemiotactic theory briefly is that the presence in the blood of certain chemical substances produced by infecting agents is capable of exercising both an attractive and a repellent influence upon the amœboid leucocyte. It would seem that different varieties of leucocytes respond to different stimuli. In one instance, pneumonia, in which the polymorphs are chiefly increased; in another, trichiniasis, we have an increase in the eosinophiles; in a third, whooping cough, where the lymphocytes are increased.

It would seem that this leucocytosis is an attempt of nature to rid itself of the infecting agent by the mechanical means of phagocytosis and by the production (possibly through the leucocytes) of chemical substances which act as bactericidal and antitoxic agents.

Following a severe hemorrhage the leucocytes jump within an hour to from 16,000 to 18,000 per c. m. In inflammatory and infective processes the leucocytes may be gradually or rapidly increased, according to the nature of the process, to two, three, or even four times their normal number. As this is one of the most important conditions in which the clinician finds a leucocytosis, and as it is the one in which the most variation occurs, it is well for him to understand:

1. That there is no connection between a leucocytosis and fever.

2. That purulent and gangrenous processes usually cause a higher leucocytosis than a serous process, for instance, the count in an empyema would probably be higher than in a pleurisy.

3. That a leucocytosis which increases from hour to hour is suggestive of an acute spreading inflammatory condition; for instance, taken along with other suggestive symptoms, a leucocytosis in typhoid, increasing each hour, would probably mean the perforation of one of the intestinal ulcers.

To make out the particular variety of leucocyte which takes part in the increase, we require to make a blood film stain in a suitable manner and then count each variety separately. An increase in the lymphocytes or a lymphocytosis is found in certain of the diseases of infancy. The one showing the greatest increase being whooping cough, in which they may be four times their normal number. This compels us to exclude whooping cough before making a diagnosis of lymphatic leukæmia, and it can only be excluded by the history and physical signs. Other conditions in which a lymphocytosis occur are cholera infantum, rickets, scurvy, hereditary syphilis.

Eosinophilia, or an absolute increase in the number of the eosinophiles in the blood, has been reported in a large number of different diseases, as in such skin conditions as eczema, leprosy, pemphigus, urticaria, in various of the parasitic diseases, and in such conditions as malaria, rheumatic fever, bronchial asthma.

The polymorphonuclear cells usually form the greatest increase in the leucocytosis of various septic conditions.

Passing from those conditions where we have an increase in the number of the leucocytes, we will consider leucopenia, which includes all those conditions in which the number of the white blood cells is reduced below the normal limit, and the fact that this occurs in some of the most important diseases (when devoid of complications) will again show the advantage of a leucocyte count as an aid in diagnosis. If, during the course of any of the diseases in which leucopenia occurs, we should get a leucocytosis, it would point to the presence of a new factor. In typhoid fever, for instance, it would point probably to one of the complications such as phlebitis, hemorrhage, abscess or perforation. Pulmonary tuberculosis, in which ordinarily leucocytosis does not occur, would show an increase in the leucocytes after the infection has become a mixed one. To point out another possible diagnostic use of leucopenia is in typhoid fever, in which there is a gradual reduction in the leucocytes after the first week, the lowest count being found about the fifth or sixth week; so that in the non-eruptive fever (rose spots being absent) a normal or diminished leucocyte count would be strongly in favour of typhoid fever. Leucopenia is found in about three-fourths of the cases of pernicious anæmia, which is in marked contrast to the tendency to leucocytosis in the secondary anæmias.

We shall now turn to a condition in which the increase in the leucocytes of the blood is wholly a pathological one—I refer to the leukæmias—and in which it is absolutely necessary that a blood examination be made before a diagnosis can be made.

Ehrlich subdivides leukæmia into two forms: (1) myelogenous or spleno-myelogenous; (2) lymphatic.

In myelogenous leukæmia the blood shows a diminution in the red cells and an enormous increase in the white corpuscles, the red cells usually averaging 3,000,000 instead of 5,000,000; but in the later stages, and especially if hemorrhages have occurred, the reduc- of the red cells may be extreme. The increase in the white cells as a rule exceeds 100,000 per c. m. instead of being from 6000 to 9000 as normal, and they may increase to over 1,000,000 per c. m.

The qualitative changes in the blood may be briefly summed as: (1) an increase in the polymorphonuclear cells; (2) myelocytes or marrow cells also circulate in the blood; (3) the three types of granulated cells, neutrophilic, eosinophilic and basophilic, all participate in the increase; (4) atypical cells and cells showing karyokinetic

figures may also be seen; (5) nucleated red cells are usually found. From this it is to be seen that the distinguishing features are not only the presence of myelocytes, but also the increase in the mononuclear cells of all three varieties of granulations, with atypical forms, and with nucleated red cells.

Lymphatic leukæmia may be acute or chronic and in either of them the leucocyte count is usually less than in the myelogenous form. The characteristic change in the blood is the tremendous increase in the lymphocytes; while in healthy blood they constitute less than 30 per cent. of the whole number of the white cells, in lymphatic leukæmia they form over 90 per cent. of the total leucocyte count. There is also a slight increase in the polymorphs, and myelocytes may be present in rare cases. Nucleated red cells are not so abundant as in the myelogenous type.

In regard to the staining of blood specimens for examination under the microscope, while each stain, such as eosin and methyl blue or eosin and hæmatoxylin, Ehrlich triacid or Ehrlich neutrophilic and the others, have each a special advantage, I find that for ordinary routine work—principally on account of the rapidity of the fixing required and the uniformly good slides produced—that Jenner's stain is the best. It is a solution of eosinate of methyl blue in absolute methyl alcohol.

If I have succeeded in interesting you for a time the object of my paper will have been attained, the attempt having been to give you a general view of the part taken by the white blood cells in disease.

THE SMALLPOX EPIDEMIC—PERSISTENCE OF THE CONTAGIUM OF SMALLPOX.

By A. P. Reid, M. D., L. R. C. S., Middleton, N. S., formerly Secretary of the Provincial Board of Health.

In common with the states and provinces to the east and west of us, we have had an invasion of smallpox that bids fair to become endemic unless more stringent efforts are made towards having the community protected by vaccination.

The chief reason for this attack continuing so long is chiefly due to two causes—the mildness of the malady, and the desire to believe that it is not smallpox—so that there is a hebitude in adopting those measures that would be promptly applied if different conditions prevailed.

Even some of our confreres have abetted the dilatoriness and indicision by assuming that it was chicken-pox or some other eruptive disease.

This is no doubt due to a want of familiarity with the conditions under which variola presents itself. These are four :

1st. *Variola discreta*—mild smallpox where each pustule is independent. Constitutional symptoms in no case severe, in some even trival, and in which death is very, very rare.

2nd. *Varioloid*—similar in every way to the above, but with a previous history of vaccination, or perhaps a mild attack of smallpox.

3rd. *Variola confluens*—the ordinary severe type of the disease, where the pustules on the face and sometimes on other parts of the body tend to run together, with very marked inflammation and injury to the skin, with sometimes diffuse cellulitis and constitutional symptoms so severe that death in from 20 to 40 per cent. of cases results, owing to debility showing itself on the heart's action, on the kidney, on the lungs, or from profuse suppuration, etc., etc.

4th. *Variola hemorrhagica*—where pustules are rarely seen, their place being filled by petechiæ, hemorrhagic effusion, death taking place very early in the attack, a case of recovery being so extremely rare as to be denied by many authorities.

From what I have seen of the disease here they were cases of the first and second type, which ran the ordinary course and were in no

way different from the peculiarities of the type. I saw two cases of confluent, one died and one recovered after a close call, and several more were reported with two other deaths. But what I would particularly desire to note is that each confluent case was the result of contact with other cases that were of the mildest type, and in some cases so mild that even the disease was not suspected, and it was difficult to trace the origin of the infection. The question of diagnosis has apparently been the crux of the situation, but I think a little observation would have solved the difficulty. I am not aware of a single well authenticated case where the disease was contracted by any one who had been successfully vaccinated, and we know that vaccination only protects from the variola toxine or infection.

A medical friend who had doubts of the attack being smallpox gave me his reason—"he had successfully vaccinated a family of five, and one of these cases had, as he supposed, contracted the prevailing malady after vaccination, and pustules appeared on shoulder and one leg in the vicinity of an old ulcer." I asked him if he had noticed that the supposed invasion was or was not coincident with the vaccination. He said it was coincident. This solves the enigma, because we know that as a result of vaccination we now and then see a crop of pustules break out at a distance and not directly connected with the vaccination marks. In the case in point very likely some inherent debility in the parts near the ulcer determined the locality of the pustules, which were an indication of the influence of the vaccination on the economy of the patient, the thing which we desire to bring about in every case, but not often so clearly visible. There were many other symptoms that clearly differentiated the malady, but as these are well known, I need not take up space with a recapitulation.

There is one view that I would specially desire to be made prominent in reference to vaccination. When I was urging on the people the necessity of vaccination, I was informed they considered vaccination more painful and annoying than the disease; that in the one case they were often two and three days sick and with a sore arm, and in the other they could go about all the time.

Looked at from a purely personal aspect there was reason in the objection, but from the point of view of the community or the public health it was lamentable. Good vaccine should cause but little annoyance, but in any case, protection of the community by the

disease means not only that it becomes endemic and keeps some of the people always sick, but they are a menace to every one with whom they come in contact, and would be quarantined wherever they went—sick or well. Again, any case of smallpox, mild or otherwise, may be a continuous source of disease for a period of two months.

Vaccination, while protecting, can not convey disease unless by direct inoculation, and it matters not how many cases of vaccination may be concentrated in a locality for they cannot become a source of disease to others.

Had we a severe type of disease every one would be scared, and there would be a rush to adopt any means of protection. As it is, the rush is the other way, and a general vaccination does not exist in the province, though some communities are much better protected than others. It looks very much as if it will take the sacrifice of many lives and a complete stagnation of business before argument will convince the people that it is in their power to avoid both, or that they can absolutely ward off an epidemic which, if it appear of a serious type, will leave a trail of death and affliction in its course.

The persistence of the contagium of smallpox is a question about which there is difference of opinion. And this is a matter of import, because on its correct knowledge depends the proper method of disinfection and the period at which a patient recovering from smallpox is safe to be given liberty of free association with others.

The following paragraph shews that under favorable conditions—darkness, dry air, and a confined locality, it is capable of retaining its virulence for twenty-seven years.

This is copied from the *Indiana State Board of Health Bulletin*:

PERSISTENCE OF SMALLPOX INFECTION.

Miss Minnie Peterson, 39 years of age, died last Monday, April 6, 1903, near Scipio, of smallpox. Her remains were brought to Brookville for interment, the funeral taking place yesterday.

The manner in which Miss Peterson contracted the disease is curious and shows that people can not be too careful in destroying contagion. We are told that her father died of smallpox twenty-seven years ago at Yung, this county, where the family then resided. The clothes he wore while ill were put into a trunk, which was locked and kept among the household effects all these years. After

her mother died, not long since, Miss Peterson set to work to clean up, and in overhauling the things about the house opened this trunk and handled the contents. In this way, it is asserted, she contracted the dreaded smallpox and lost her life.—*Brookville American.*

Coming down to every day experience I will give an instance that in so far as I can make out is reliable:

A Mr. T. —— came from New York to Church Point, Clare, having a certificate from the infectious diseases' hospital in New York that he was admitted there on December 24th, 1900, and was discharged well, thoroughly bathed and disinfected (?) February 28th, 1901. He came home by Boston, and two weeks after his return, his brother, with whom he slept, contracted smallpox, and also every member of the family, but owing to strict quarantine, no other case of the disease occurred in the locality.

I wrote twice to hospital in New York, but got no answer.

A Mr. X——took a business trip to Boston from Kentville; was away two weeks and returned, never having, as far as he knew, any association with any source of the disease. However, he came from Boston in the same steamer with the above Mr. T. ——, but had no special relations with him.

A fortnight after his return Mr. X—— had malaise, but not confined to bed, and his doctor suspected nothing. His daughter also got sick, but with symptoms not sufficiently pronounced to cause suspicion. A friend, Mr. M——, with whom Mr. X—— was very intimate, got sick, and Dr. M—— asked me to see the case. On doing so I had no hesitation in diagnosing smallpox with great probability of its being confluent. This took place, and he died in ten days' illness with smallpox of most severe type.

Miss McC—— taught school some miles from Kentville, where there had not been any of the disease. She, however, contracted smallpox of virulent type and died. The only explanation that appears in this case is that probably some protected child had attended the school and conveyed the disease. I can conceive that the harmless lead pencil which is so often carried to the lips may have been a vehicle by which Miss McC—— contracted the disease.

A Mr. Y—— was at work in the gravel pit on railway at Kentville, at which, as far as he was aware, no person with the disease was present. He went home to Bridgetown and had a very high temperature (105°) for three or four days. I was consulted. The face

was suffused, etc., but no appearance of papule or *shot under the skin.* The ordinary precautions were instituted as a matter of prudence. Next day granules could be felt under the skin of the forehead. A confluent case of smallpox developed and he barely got through.

Strict precautions and quarantine prevented any spread of the disease.

So I might go on with numerous examples, but they would all go to show that strict quarantine and disinfection are matters of business not sentiment, and that the custom adopted of requiring the strict seclusion of a smallpox patient for two months after the crusts or scabs fall off is as soon as it is safe to allow such a patient to have full liberty, and even then it is necessary that more than ordinary care be taken in disinfection of the domicile, clothing, bedding, etc., as well as of the person of the patient.

It is surmised that the exfoliation of the skin contains the contagium in its most virulent form; but, even when the epidermis has been removed, the next covering is still virulent though likely in a less pronounced form.

Each subsequent exfoliation is less virulent, but even two months after there is not the certainty there is no contagium, though it is not probably present in a dangerous form.

Very likely in the first case mentioned, had Mr. T—— not slept with his brother the disease might not have been propagated, for we can conceive that such close contact would permit the inhalation of the exhalations from the skin and epidermic scales which were specifically contaminated, which under other circumstances might not have been productive of disease.

This department of the sanitation of smallpox is apt to be lax and may to some extent explain the wide distribution of the disease in the eastern part of the province.

CLIMACTERIC INSANITY.*

By G. A. B. Addy, M. D., St. John, Pathologist to the Province of New Brunswick.

Normal signs of the menopause are largely confined to nervous and mental change of a minor kind, and are present in varying degrees in most women. At the ordinary menstrual periods, the susceptibility of the nervous system to various, even slight, stimuli is considerably increased. Many women—it is well known—are at these periods unduly sensitive and inclined to be irritable and dispirited. They are also more or less whimsical and lose their control over slight occurrences.

At the climacteric, however, these or similar manifestations, even when not intensified, are especially prominent because they are attended with increased frequency and usual abundance of the uterine flow in many cases, and because of the length of time elapsing before complete cessation of the menses takes place.

Although the phenomena which characterize the menopause are chiefly of the nature of slight mental or nervous disturbance, actual insanity in the form of a first attack, and directly and solely attributable to the menopause, is far from frequent. It would seem as though the relatively limited and special nature of the change precluded to a great extent the possibility of profound mental disturbances, and was perforce confined to a set of less pronounced disorders. Sutherland believes that mental trouble amounting to actual insanity is extremely rare at the "change of life". Merson, whose monograph on this subject is very thorough and exhaustive, considers that the histories of the cases which he has investigated point to the conclusion that the menopause is not of itself the immediate cause of their insanity. Mitchell is convinced of the fallacy of attributing melancholia to the menopause, and his statistics show that of all insanities but two per cent are due to that cause. Lewis' ratio is 4.4 per cent. Statistics on this point are, however, widely divergent, and there is little room for doubt that the number of cases of true climacteric insanity would have been smaller and the percentages more uniform if the cases selected had been invariably and exclusively confined to

*Read before the St. John Medical Society, Dec. 9th, 1903.

those which originated during the actual progress of the menopause and were uncomplicated by other causes. This inaccuracy does not prevail in reporting cases of puerperal insanity, the starting point of which is always shown to be within the parturient period. The apparent laxity is probably in a measure due to the difficulty that exists in ascertaining the first appearance of the menstrual irregularity which marks the menopause.

Although, as Clouston truly remarks, the mere cessation of function does not necessarily fix definitely the mental and nutritional changes that mark the period, and that therefore the mental disease that accompanies the climacteric need not be coincident with the menopause; nevertheless the more remote the attack is from the menopause, the more room will there be for the operation of the other causes, and there are a multitude of the morbid influences, mental, moral and physical, direct and indirect, to which women are exposed at this time of life.

Attacks of recurrent insanity at this period have also served to swell the number of cases of "climacteric insanity" in tables of statistics. They are obviously of much earlier origin, as a rule, and should be rejected from the category. Finally, competent opinion as to the baleful effect of this physiological change with regard to disease in general has greatly altered in the past twenty years, and the menopause is no longer looked upon as an experience fraught with peril and difficulty.

We can therefore only say, as regards the relation of the menopause to mental disease, that it may be the final factor in the causation of attacks of insanity in occasional cases in which a bad heredity, with or without other influences, has been previously inoperative.

The menopause is, however, quite an effective influence in cases of insanity with a history of previous attacks. In other words, when the hereditary taint is marked and previous attacks of mental disease have been undergone, there is reason to fear that the menopause will give this tendency to mental disturbances an increased acitivity which will be sufficient to precipitate a relapse.

Nevertheless, although the influence of the menopause itself is a minor one in this direction, there is a general and recognized condition of the organism which attends the middle life in both sexes, and in which the period of the menopause is excluded, that is characterized by diminished vigor of body and mind, lessened interest

and ambition, perhaps unnecessary anxiety, and a tendency to become more easily disturbed than usual. It is due to the failure of the system properly to adapt its powers to meet changed conditions or increasing demands on its resources. This period, which represents an involution of the mental faculties, begins earlier in women than in men, being probably hastened by the menopause, which in turn aggravates the condition. This soil is a most fruitful one for mental disease, especially in hereditarily predisposed. By far the most frequent form that it assumes is melancholia, which may be of any grade. This, the melancholia of involution, as it is termed, embraces most of the melancholias except the depressed states occurring in the course of dementia præcox and organic dementia; and properly includes nearly all cases designated as "climacteric insanity," for which few writers have ever claimed distinctive mental manifestations and in which ordinary melancholia has always been found to be the prevailing condition. The limits of melancholia of involution, as given by Kraepelin, are, from the fortieth to the sixty-fifth year, sixty-four per cent of the cases occurring between fifty and sixty.

Although melancholia is the usual mental state at this time of life, several others are not infrequently met with. The peevishness, ill-temper, and ungovernable anger of previously amiable and reasonable women, occasionally amount to a condition resembling "moral" insanity. Sudden repugnance to the dearest members of the family has led women at this time to tyrannize and hate others of the household, and even to desert their husbands. Primary delusional insanity is not uncommon, and paranoias heretofore latent are apt to crop out under the stress of this period. The simplest type of these conditions consists in systematized delusions of persecution without necessarily any defect in intelligence. (Berkley.) A craving for stimulants may manifest itself, possibly through a desire to meet or appease the anomalous sensations at the epigastric region, so common in women at this time.

The prognosis of all mental disturbance, occurring during the period of general involution, is good, as a rule, in uncomplicated but acute cases. The duration, however, is somewhat longer than that of insanity occurring at other times of life, owing to the protracted nature of physiological change underlying it.

REMARKS ON OCULAR PARALYSIS, WITH CASE REPORT.*

By G. R. J. Crawford, M. D., St. John, N. B.

Mrs. A., aged 50, Jewish pedlar, states she was brutally attacked by a man and dealt a severe blow on the side of the head, knocking her down and rendering her unconscious. Next day she recovered consciousness, but found she was unable to open her left eye. At this time she noticed objects were seen doubled, and this resulted without lifting the lid artificially. Patients suffering from ptosis, by raising the head, can, as a rule, open the palpebral fissure sufficiently to bring about diplopia if any paresis of the external ocular muscles is present. On applying to the St. John General Public Hospital for relief she gave the history of the accident as briefly detailed above.

Examination showed all the characteristic symptoms of paralysis of external muscles of the eye, viz:

(1) Deviation of the eye (outward in this case); (2) diplopia, in every direction but that of the action of the intact external rectus; (3) false projection of the retinal images corresponding with the defective or paralysed muscles; (4) secondary squint in excess of the primary deviation. If there had been no ptosis no doubt there would have been present another objective symptom, viz: a turning of the head in the same direction as the paralysed side and muscles. This expedient will fuse the double images and relieve the dizziness and uncertainty in walking, so distressing and annoying to the patient.

In short the patient presented all the characteristic symptoms of incomplete ophthalmoplegia externa of the left eye. This paralysis would have been complete had not the external rectus escaped. A case of ophthalmoplegia externa totalis is certainly very rare and would present a very striking picture indeed; the eye looking forward, staring and immovably fixed as if set in cement. The interior muscles—the sphincter of the pupil and ciliary muscle—were unaffected.

The chief point of interest in this case is as to the nature and location of the lesion and nothing more than a guess can be made in answer to this question.

*Read before St. John Medical Society, March 10th, 1904.

Here we have from the patient a history of sudden paralysis which she claims immediately follows an injury. There was no history or evidence of any constitutional disease liable to cause pressure symptoms or degenerative nerve lesions. There is not a single symptom pointing to orbital disease either within the orbit or at the point of exit of the oculo-motor nerves. It seems impossible to conceive pressure or disease in the track of the third nerve so limited as to effect the branches to the external muscles and leave the fibres to the internal muscles intact. In chronic degenerative changes in the nucleus of the third we have just such symptoms as I have detailed, but an acute disease or a traumatism so circumscribed must certainly be exceedingly rare.

A nuclear etiology is probable from the fact that in most of those cases the interior muscles of the eye (those for the pupil and accommodation) escape, probably from the fact that the part of the nucleus which supplies those muscles lies furthest forward, and that they also belong to a different vascular district.

There are a few cases of an acute affection of the gray substance of the nucleus described by Wernicke and called by the very expressive name of polioencephalitis superior.

This has been an exceedingly puzzling case, and I hope some of my brother practitioners of larger experience may be able to help and clear away some of the difficulties in the etiology of a rather interesting case.

The treatment in this case was merely tentative. I gave large doses of potassium iodide up to one dram three times daily. There has been marked improvement. The patient can now open her eye without difficulty, and the internal rectus has completely regained its power.

Selected Article.

DON'TS IN MODERN GYNECOLOGY,

By Lucien Lofton, A. B., Phg., Belfield-Emporia, Va., Ex-President Seaboard Medical Association of Virginia and North Carolina.

Don't tell a patient with merely an eroded os that an operation, will be necessary. Treat the condition always first.

Don't make digital or macroscopic examination too lengthy.

Don't attempt to mix private matters with the sacred science of gynecology. The two are incompatible.

Don't even criticize a woman who is unclean. Remember ignorance plays no uncertain role in the life of everyone, hygienically speaking.

Don't ever display anger while making any exploration. Gent eness politeness and kindness are the cheapest and most effectual weapons one may possess in all vocations.

Don't depend on a female patient to carry out your initial instructions, but show her yourself. Results come then.

Don't make a hurried digital examination because you may have to make many. Once well done relieves constant and unwarranted dread upon the patient's part.

Don't criticize a lacerated perineum. No women likes to be reminded that her much-loved accoucheur did her wrong, when she wasn't looking.

Don't remove an ovary if you can remove the pain. A sexless woman is a slab-stone upon the waning popularity of the excessive debauchery of abused woman.

Don't pronounce every abdominal pain of ovarian origin. Women are surely susceptible to appendicitis and mostly every other ache to which the stern sex is liable.

Don't call upon the surgical world to note your matchless method of doing a hysterectomy, but rather call upon all the science and skill that within you lies to save every poor sufferer the humiliation of such a formidable undertaking.

Don't forget that narcosis has removed many enormous cystic (?) tumors in its time.

Don't attempt the specialty of gynecology without cause, a wagon load of "horse sense" and years of experience. There are men in business who have been in harness for several decades, who are still staying very near the bank, and who will not approach deep water, save under high pressure.

Don't thrust upon a neurotic the appalling news that her condition is always due to an abnormal position of her womb.

Don't tell a candidate she has "falling of the womb." Thousands go around every day expecting this shamelessly censured organ to fall between their knees any moment.

Don't delude a woman into beliving her uterus is pinned to her spinal column, or that it is twisted upon its axis, or that it is bent upon itself, so that only the recumbent position will cure her. Tell her little. Do for her much and your name will receive a divine blessing at her hands.

Don't stuff a vagina too tightly with your gauzes, your wool or your cotton. There is nothing more disagreeble than an unnatural foreign body hereabouts.

Don't treat all female comers for some disorder pertaining to your branch, remembering that they might occasionally be affilicted with something else the other fellow can do.

Don't be narrow in your conclusions. It requires two halves to make a whole: and often more.

Don't deny any woman the right to suffer if she so disposes. If one makes her bed a hard one, she alone must lie upon it.

Don't express too much sympathy for your gynecologic applicants, ahould you desire to be successful. It is medicine to some but ruinous to the majority. Kindness is a different proposition altogether.

Don't inform the married patient she has specific urethritis. Ninty-nine times out of a hundred the husband will advise his wife to go to some other physician, and that you are a genuine humbug.

Don't deny the husband marital rights only when absolutely necessary. Always take into consideration a married couple is like a pair of scissors; come between them and you suffer.

Don't estimate your surgical skill by the number of ovariotomies you have done, but rather by ones you haven't done.

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WHOLESALE AND RETAIL. Please mention the MARITIME MEDICAL NEWS.

Don't ever suspect the wife of contaminating the husband with gonorrhea, until after you have thoroughly overhauled the gentleman in question, for all husbands are not innocent even if they were born so.

Don't pronounce every vaginal discharge of your patients leucorrhea,for variety is the spice of married life, even with many "amen" "hubbies."

Don't use diluted phenol in your vaginal practice. Many corroded services originate in this way. Use the simon pure article for cauterization only.

Don't breathe the name of a sexless woman. Eunuchs are no less despised than this class of unfortunate martyrs.

Don't fail to learn early in your career that your tongue is the keenest instrument you may possess and like a scalpel, should be used only when absolutely necessary.

Don't abruptly terminate your acquaintance with an aggravated case, as success comes slowly, and impediments should always stimulate you.

Don't think you will cure every female who places her case in your hands. Should this be true, nothing would be left to whet your ambition on.

Don't testify before any tribunal against a gynecologic patient, where virtue is involved. A cell for contempt of court in this instance is far better than having the contempt of all the petticoats.

Don't cure your female patients too quickly. No woman as a rule is willing to submit to treatment unless she has been convinced that her's is a complicated case.

Don't content yourself with being masterful and invincible. Too much confidence in his skill and ability brought the great Napoleon to his Waterloo.

Don't forget finally that the poorest and humblest may be as modest and as chaste as the highest and richest.

American Journal of Surgery and Gynecology.

THE
MARITIME MEDICAL NEWS.

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Editorial.

THE PROVINCIAL SANITARIUM AT KENTVILLE.

We have much pleasure in announcing that the sanitarium at Kentville for the treatment of tuberculosis is now completed, and is about ready for occupation.

Four years ago, the Government of Nova Scotia, influenced by various considerations, secured authority from the Legislature to build, equip, and maintain a sanitarium for the treatment of patients suffering from tubercular disease. The memorials of representative organizations of the profession and the example of other provinces were mainly instrumental in influencing the decision of the Government. It was realized that it would be impossible for the Government to provide for an institution capable of accommodating all cases of tubercular disease, amenable to treatment, occurring in the province. Therefore, it was deemed best to construct and support a small but thoroughly equipped sanitarium which would serve as a model for like institutions, which it is expected that the various towns and municipalities will make provision for in the near future.

In carrying out the scheme, due haste has been avoided, and advice has been freely and widely sought. The selection of a suitable locality, the choice of a site, the design of the building, the internal equipment, and the management of the institution were only decided upon after mature consideration and consultation with competent medical authorities both at home and abroad. At all times the

practical knowledge and experience of Dr. Geo. L. Sinclair have been available. The selection of Kentville is very generally approved of, the climatic conditions being perhaps better than any other section of the province. The site and building have been recently described in the *Morning Chronicle*, from which we take the following extract:

"The new building at Kentville is beautifully situated on an abrupt hill slightly at the northwest of the town, giving sun, light and air free access on all sides. The patients' rooms, all facing south, have a beautiful view of the river with its many curves and windings lying at their feet. Across the way is the busy town, half hidden in the trees, and just beyond lie the Caanan Hills, and over these the mountain. The long slopes to the east and west are dotted here and there with houses, and the dull blue of the distant wood and the nearer distant green blend harmoniously into a beautiful picture on which one never tires of looking.

At the east of the building and overlooking the meadow road leading to the sanitarium is a grove of pines which send out their healing odors with every breeze. On the north is a good view of the mountain, and grim old Blomidon may be seen in the distance. Altogether the charm of the place and its natural beauty makes one realize that it is not a place to be sick in but one in which to find health and strength.

The building itself harmonizes with its surroundings, its massive proportions lending themselves to the situation, and the dull brown and green coloring of the building carry out the color scheme of the landscape."

The building cost $20,000, and has accommodation for eighteen patients.

The matron appointed is a lady who has had a long experience in nursing, and recently has spent many months at a large sanitarium in Massachusetts. No announcement has been made in respect to the medical management of the institution, and many reports are current. The conditions of admission are specified in Chap. 9 of the Acts of 1900:

"So soon as said sanitarium, the erection of which is authorized by this Act, is completed, equipped and ready for the reception of patients, the Governor-in-Council shall appoint one or more registered medical practitioners, practising near said sanitarium, examiner or examiners, and no person shall be received into said sanitarium as a patient for care or treatment until he or she has been examined by one of said practitioners, and such practitioner has certified that such person is suffering from tubercular disease of the lungs in its first or

incipient stage, and that the care and treatment which can be furnished at said sanitarium may produce a cure. Such examiners shall receive the fee of $3.00 for each examination, and shall furnish the certificate free when proper to do so. They shall keep a record of each applicant, with such particulars as may be prescribed by the Governor-in-Council, and make an annual return thereupon to the Provincial Secretary on or before the 31st of January in each year."

It is said that a resident medical superintendent is not likely to be appointed. We trust the report is incorrect. The profession recognizes that successful results can only be obtained by close attention to the many and minute details of treatment which require constant modification to suit individual cases. Each case will call for close and continuous study and the exercise of tact, and no one except a specially trained medical man can carry out the work, and enjoy the confidence of the medical profession and patients.

CANADIAN MEDICAL ASSOCIATION.

As already announced in these columns the 37th Annual Meeting of the Canadian Medical Association will be held in Vancouver, from the 23rd to 26th of August. Those who contemplate attending this meeting should put themselves in communication with the General Secretary, Dr. George Elliott, 129 John Street, Toronto, without further delay, as it is imperative that all delegates must present a certificate to the railway ticket agents from the General Secretary, certifying to their membership, or that they are delegates to this Convention, if they desire to take advantage of the reduced rates. The return fare can be readily ascertained from any ticket agent and this fare will be single first-class rate to Chicago, plus $50 from all points east of Port Arthur. From all points in Ontario and Quebec, tickets will be on sale from August 15th to 21st inclusive, and from points east of Vanceboro, Maine, August 14th to 20th inclusive, final return limit being October 23rd, which means that degelates must reach home that day. Tickets will be issued good going via Canadian Pacific Railway, via Port Arthur, or Sault Ste. Marie, St. Paul, thence Soo-Pacific route, Great Northern and Northern Pacific Railways;

returning same route or any of the above routes. It is also proposed to allow variation via St. Louis from St. Paul and Chicago on return trip on payment of $10 additional. Stop-overs will be granted west of Port Arthur on going and returning journey and west of St. Paul when tickets are routed on return journey by that point. Those who wish on return journey to visit the Yellowstone Park can do so on payment of the extra charge made for the trip through the Park from the junction with the Northern Pacific Railway at Livingstone. The arrangements as to rates in Manitoba, Northwest Territories and British Columbia are as follows:—From Port Arthur, Fort William, Rat Portage, $50; from Winnipeg, Emerson, Gretna, Portage La Prairie, Brandon, Indian Head, $45: from points in the Northwest Territories, Qu'Appelle and West, round trip tickets to Vancouver and Victoria, B. C. will be issued at single fare. These rates cover the transportation of degelates and immediate members of their families. Passengers ticketed at stations Medicine Hat and east have the option of going via the main line and return Crows Nest or vice versa when purchasing tickets. Already a fine list of papers has been promised and there is every indication that this meeting will be one of the most successful in the history of the Association. It is not likely that there will be any special train.

The following gives an approximation of the rates from all points east of Port Arthur: Toronto, Brandford, Hamilton, Windsor, Chatham, London, Stratford, Guelph, Orillia, $62.40; Montreal, Ottawa, Brockville, $68.00; St. John, N. B., $76.50; Halifax, via I. C. R., $81.00; Sydney, $83.70. Winnipeg and points in Manitoba, $45.00, but full arrangements for this have not as yet been fixed.

Society Meetings.

NOVA SCOTIA BRANCH BRITISH MEDICAL ASSOCIATION.

March 2nd. Meeting held at the Halifax Medical College, the President, Dr. F. W. Goodwin, in the chair.

Dr. L. M. Murray read a paper on "The White Blood Cells in the Diagnosis of Disease," and showed blood slides illustrating some of the conditions. (Published in this issue.)

Dr. W. G. Putnam, of Yarmouth, then read a paper on "Iritis." (This paper will be published in the NEWS.)

Dr. Kirkpatrick congratulated Dr. Putnam on the excellence of his paper. The classification he followed in his teaching was: (1) plastic, (2) serous, (3) purulent; and the etiological conditions: (1) rheumatic, (2) syphilitic, (5) traumatic, (4) sympathetic, (5) gonorrhœal, (6) tubercular.

Dr. Kirkpatrick reported a case to show the importance of early treatment. The patient who was shown was a young girl of 16 years. Last August she had an attack of acute rheumatism and a second attack in October, when iritis developed. She received no treatment till December, when complete synechia had formed, which later was followed by extensive staphyloma of the sclera. The eye had to be be enucleated. Early instillation of atropine would have saved the eye. Reference was made to atrophinism, viz: redness and swelling of the conjunitiva, muco-purulent discharge and swollen lids; and the general symptoms: clammy skin, dryness of the fauces, thirst, hallucinations, and delirium. He also referred to syphilitic iritis as a secondary manifestation of acquired syphilis, and in inherited cases especially about the time of puberty. He agreed with Dr. Putnam in the treatment. He also called attention to the good effect of Baume-analgesique applied over the supra-orbital nerve for the relief of pain in that locality.

Drs. Mathers and Ross also discussed the paper, the latter referring to a case of syphilitic iritis in a girl aged 12, there being manifestations of inherited syphilis in several members of the family.

Dr. Hare reported a case of diphtheria in a child in whom the inter-ventricular septum was patent.

A vote of thanks was passed to Dr. Putnam for his interesting and instructive paper.

March 16th., meeting held at the City Hall.

Dr. John Stewart read a paper on "Carbolic Acid in Surgery." Reference was made to Lister's work on the subject, and many reasons were given why carbolic acid was preferable as an all-round antiseptic. The effect of carbolic on the surgeon's hands he did not think any worse than the other antiseptics. Carbolic could be used both for sterlizing the hands and the instruments. Most of the objections to carbolic acid could be tracted to the inferior quality of some on the market. Several different makes of the acid were exhibited and the tests for their purity were shown and carefully explained.

Dr. Stewart places his instruments in a five per cent. solution of carbolic acid for half an hour before using them. The skin of the patient is cleansed in the usual way, and a carbolic acid compress applied some time before the operation. He always uses marine sponges, soaking them after operation in a solution of ammonia. They are then washed in water after which they are placed in a five per cent. carbolic solution.

Dr. Chisholm said that carbolic acid was becoming more and more a favourite with him. He referred to its use in cases of whitlow, followed by alcohol. He also spoke of its use in typhoid fever.

Dr. Murphy compared carbolic acid and bichloride of mercury and his preference to the latter as a rule.

Dr. Hattie exhibited a sample of urine, showing the condition of fibrinuria, passed by a patient at the Nova Scotia Hospital.

Dr. Chisholm reported a case of middle ear disease following measles. The points of interest in the case were : hæmorrhages from the ear and paralysis of the opposite hand and leg after mastoid operation. Pus was evacuated and the paralysis disappeared ten days afterwards. He had used acetozone as an antiseptic.

March 30th. A discussion on "Diseases of the Prostate Gland" was the programme for the evening.

Dr L. M. Murray read a short paper describing the anatomy of the prostate, afterwards explaining in a clear and concise manner the pathology of its different diseases, such as acute and chronic prostatitis, enlargement and tubercular disease of the gland.

Dr. Ross discussed the prostatic inflammations, and alluded to the fact that chronic prostatitis was a common affection, as a sequel to gonorrhœa. Many acute cases were often carelessly called cystitis, and many chronic cases were overlooked. He also showed a number of instruments and appliances used in diseases of the prostate and particularly praised the good effect obtained from Dowd's spray in chronic inflammation of the gland.

Dr. Murphy said that the surgeon met prostatic cases after they had been treated for years by the general practitoner. Indeed they seldom sought surgical advice until catheter life had become unendurable. So he would limit his remarks to operative treatment in prostatic hypertrophy.

The technique of Alexander's operation with its modification by Syms and others was described. Vasectomy and castration as practised by White and Harrison was mentioned. McGill's work and its perfection in the present Freyer operation was referred to. The speaker favored the latter operation and said amongst other things, that one of the strongest points was that if the prostatic urethra was tortuous it was removed, and thus a better result was obtained. In cases where operative interference had been delayed too long, and there was great thickening of the bladder, the only operation to consider was supraspubic drainage, by means of a rubber tube, connected with the urinal worn by the patient. He quoted cases who had worn such apparatus for years and had been comfortable until death ensued frem some other cause. In conclusion he made an appeal for earlier operation in prostatic hypertrophy.

Personals.

The NEWS extends to **Dr. F. E. Lawlor,** its deep sympathy in the recent death of his father, Mr. A. E. Lawlor, of Dartmouth.

Dr. W. H. Macdonald, of Antigonish, has returned from his trip to Jamaica, feeling considerably improved in health. May the genial Doctor long be spared to enjoy many happy years.

The catalogue of the Cogswell Library has just been issued in a neat and handy form. Copies may be had by applying to the Librarian, Dr. L. M. Murray, of this city.

Dr. W. H. Hattie and Mrs. Hattie have just returned from their trip to the West Indies. We are pleased to state that Dr. Hattie has much improved in health.

The house staff who have just finished their year's duties at the Victoria General Hospital was one of the most efficient and popular in the history of the Hospital, and well deserve a prosperous future.

Dr. J. R. Corston, is now at his home and will probably begin practice in the northern part of the city.

Dr. J. L. Potter is now stationed at Stellarton.

D. J. F. Lessel is taking **Dr. MacKenzie's** practice at Port Mulgrave for a few weeks.

Dr. G. W. Whitman has located as Shubenacadie.

Dr. Fred. Miller has been appointed physician to the Imperial Government Steamer "Elinor" which boat will be employed for surveying purposes on the coast of Newfoundland. The "Elinor" was formerly the Duke of Manaco's private yacht.

The new house staff at the Victoria General Hospital are **Drs. A. R. Cunningham, J. Rankine, C. E. A. Buckley, T. R. Johnson** and **M. A. MacAulay,** all recent graduates of Dalhousie University.

The last graduating class in medicine at Dalhousie numbered fifteen. No less than four were ladies, one particularly, **Miss Jemima MacKenzie,** standing high in the examinations.

Dr. A. R. Cunningham, son of Dr. N. F. Cunningham of Dartmouth, won the medal for the best examination in the final subjects at Dalhousie.

Dr. G. L. Foster has removed his office from 184 Pleasant St. to 66 Spring Garden Road.

Dr. W. D. Forrest has moved to 178¼ Pleasant St.

Dr. E. L. Lowerison has removed to the Queen Hotel.

Obituary.

Dr. W. W. Wickham.—It is with deep regret that we announce the death of Dr. W. W. Wickham, of Tignish, P. E. I., which occured at St. Agathe, Quebec, on the 14th inst. On account of failing health Dr. Wickham had gone to St. Agathe three months ago but unfortunately the change proved unavailing. He was 36 years of age, and graduated from McGill University, in 1895. Since then he practised his profession at Tignish. He was married in June last to Miss Katie C., daughter of A. J. McFadyen, Esq., of that town. Active in politics and a pronounced Liberal, if his health had permitted the doctor would undoubtly have received political honors from his fellow citizens, by whom he was greatly esteemed for his many excellent qualities. The doctor was a son of Mr. William Wickham of Summerside, and also leaves a mother to mourn. Both his brothers pre-deceased him. One was the late J. J. Wickham, Superintendent of Education in St. John's Nfld., and the other was J. P. Wickham who held the position of Principal in Queen's Square School, Charlottetown, for a number of years.

Visitors to the meetings of the Maritime Medical Association at Charlottetown will well remember Dr. Wickham,—his kindly nature and hospitable character. We deeply sympathize with all his relatives and friends in the early death of one who was so greatly esteemed by his confreres in the maritime provinces.

Matters Medical.

THE WISE CORONER'S JURY.—The champion verdict from a coroner's jury is reported from Mason, the seat of Ingham County, says the Grand Rapids Press. The body of an itinerant peddler was found in his waggon upon a country highway, and it was first suspected that he had been murdered by tramps. The coroner summoned a jury of farmers, and, after taking all obtainable testimony, the jurors retired. When they emerged they presented a signed verdict that the man had died "by a visitation of God and in a natural way."

This beats the ordinary Kent County verdict all hollow. For years it has been customary here, when no other cause could be guessed, to charge it to heart failure, as the heart always ceases to beat when death comes. When in doubt, too, the advice of Hoyle has been followed by leading a trump in the form of charging it "to a person or persons unknown," or when it has been desired to clear away any possible suspicion of blame, an extra flourish has been put on "with no blame attached to anyone." It can be readily seen, however, that the Ingham County verdict is not only more satisfactory, as it places the responsibility where it can not be evaded, but it is also a striking novelty.—*State Republican, Lansing.*

Therapeutic Notes.

SANMETTO IN HEMATURIA WITH RETENTION OF URINE.—I prescribed Sanmetto in a case of hematuria with retention of urine. The patient had improved a great deal by the time another supply of Sanmetto reached me. I was obliged to withdraw the urine with a catheter for nearly a week, from three to four times in twenty-four hours, also had to wash out the bladder and use suction to withdraw the clots. Since using Sanmetto the urine and the patient has fully recovered, with the exception of a small quantity of albumen. I shall prescribe Sanmetto in the future if cases for which it is indicated fall to my care for treatment.

Macungie, Pa. W. B. ERDMAN, M. D.

WHEN YOUR CASE IS WEAK ABUSE THE OTHER SIDE.—This maxim has been a favorite standby with the legal profession from time immemorial and unfortunately certain pharmaceutical manufacturers have recently seen fit to make use of this maxim. This is particularly true of the manufacturers of a certain iron preparation.

The impudence and effrontery with which these people try to hoodwink the medical profession is rather remarkable.

No other preparation ever came before the medical practitioner with so little detail as to methods of preparation, composition, therapeutic effect, etc., etc., and nevertheless the profession is asked to accept the wildest and most extravagant statements as to its wonder-working capabilities. This is not all. The makers of this preparation, in seeking the support of the profession covertly attack and sling mud at all other iron preparations that have been before the profession for years. They single out Pepto Mangan, a combination of which has stood the test of the leaders in the scientific medical world both here and abroad, an organic iron combination in which, in its results, the general practitioner and the hospital clinician have learned from experience to place implicit confidence.

This unbusinesslike method of attempting to cast discredit upon other reliable and thoroughly tested combinations we cannot term otherwise than despicable, and furthermore we know our readers cannot be influenced by unsupported statements of financially interested parties, but will always bear in mind that Gude's Pepto-Mangan was submitted to the profession as an organic iron product, and the results obtained by its use, as also the scrutiny of analysis by chemists of repute, substantiate all that has ever been claimed for it.

Attempting to foist upon the attention of the physician a product simply by insinuation that known articles are inferior, is a manner of doing business which should receive the stamp of disapproval by every one of our profession. Editorial, *The Toledo Medical and Surgical Reporter, April, 1904.*

Aural Congestion with Threatened Abscess. By C. L. Steensen, A. M., M. D., Professor of Materia Medica, New York. Author: "Naso Pharyngeal Disorders," Etc., Etc.,—I would like to mention to my confreres that, in the treatment of acute attacks of aural congestion with every indication of suppuration, both internal and external, and seriously jeopardizing the tympanum, and not infrequently with evidences of threatening abscess accompanied with the most lancinating pains, I have prescribed Antikamnia and Salol Tablets with most satisfactory results The congestion, fever and pain promptly yield to the persistent use of these tablets, and to attain this I ordered two tablets to be given every two hours. I am firmly convinced that with careful ablution and syringing of the external aural cavity with a mild antiseptic and anodyne solution, and the administration of this remedy I have aborted the threatened attack and thereby undoubtly saved the patient from a suppurative sequela, and no doubt in many instances, from operative interference, necessitating the trephining of the sphenoid, or the opening of the antrum to save life. As every practitioner knows, the operation is not infrequently fatal, particularly if the case be an advanced one and the patient an aged one.

As to the local application, I simply resort to tepid water, to which may be added a mild antiseptic, say five grains boric acid to each ounce and a little tincture opium. This makes an admirable application. This solution carefully injected from two to four times daily to warm and cleanse the vestibule of the ear, and with the administration of Antikamnia and Salol Tablets, or Antikamnia and Codeine Tablets, the practitioner will be rewarded with most gratifying results.

THREATENED ABORTION

In these cases Hayden's Viburnum Compound exerts a sedative effect upon the nervous system, arrests uterine contraction and hemorrhage and prevents miscarriage. It has proven of special service in habitual abortion.

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This condition, which prolongs labor and so rapidly exhausts the patient and endangers the life of the fetus is of common occurrence. H. V. C. acts most promptly and effectively and is not a narcotic. No less an authority than H. MARION SIMS, M. D., said:

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A more convincing argument could not be presented.

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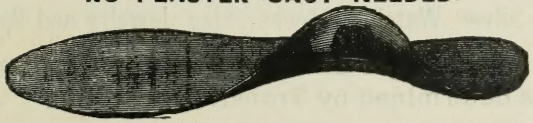

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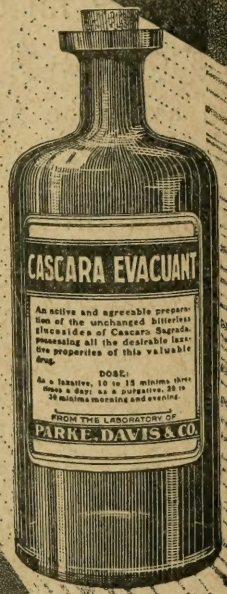
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